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**Overview  
Primary Care Curriculum**

Lori Raney, MD  
Consultant, NCBH

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**Primary Care Providers Working in Mental Health  
Settings:  
Improving Health Status in Persons with Mental  
Illness**

Lori Raney, MD  
With: Katie Friedebach, MD, Todd Wahrenburger, MD,  
Jeff Levine, MD, Susan Girois, MD

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**About the Speaker  
Lori Rainey, CEO, Collaborative Care Consulting**



Dr. Raney is the Medical Director of Axis Health System in Durango, Colorado. She has worked in the design and development of collaborative care models, including developing the psychiatric consult model for integrating primary care and behavioral health in southwest Colorado. Her work extends this model to Federally Qualified Health Centers, Rural Health Centers, School-based Health Centers and more recently a Patient Centered Medical Home. She is the Project Manager for an Advancing Care Together grant to assess the outcomes of this innovative concept. She attended medical school at the University of North Carolina in Chapel Hill, NC and completed her psychiatric residency at Sheppard-Enoch Pratt Hospital in Towson, MD. She is board certified by the American Board of Psychiatry and Neurology.

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These Modules are intended for Primary Care Providers working in public mental health settings, which is a growing trend across the country, to deal with the concerns with the health disparity experienced by patients with serious mental illnesses (SMI).

The goal is to help facilitate their work in this environment, which may be unfamiliar to many PCPs, so they can best serve this population of patients.

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**Modules**

**Module 1:** Introduction to Primary and Behavioral Health Integration

**Module 2:** Overview of the Behavioral Health Environment

**Module 3:** Approach to the Physical Exam and Health Behavior Change

**Module 4:** Psychopharmacology and Working with Psychiatric Providers

**Module 5:** Roles for PCPs in the Behavioral Health Environment

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**Module 1**

**Introduction to Primary Behavioral Healthcare Integration**

Learning Objectives:

- Appreciate the reasons for premature mortality
- Know SMI and GAF definitions
- Recognize diagnostic features of the major disorders
- List the current models of care for providing primary care in behavioral health settings
- Know the Core Principles of Integrated Care

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## Pre Test Questions

1. The premature mortality seen in the SMI population is:
  1. 25 – 30 years
  2. 20 – 25 years
  3. 15 – 20 years
  4. 10 – 15 years
2. What percent of illness contributing to this early mortality is preventable?
  1. 20%
  2. 40%
  3. 60%
  4. 80%
3. What are the leading illnesses that contribute?
  1. Cardiovascular
  2. Infectious disease
  3. Cancers
  4. All the Above

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## Overview of Module 1

- What is the problem?
- Why is this a problem?
- Define the target population
- Specific diagnosis included
- Barriers to treatment
- Cost issues
- What models are out there?
- Spectrum of collaborative care

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## Why primary care services in mental health?



- High rates of physical illness in mentally ill
- Premature mortality
- Patients with mental illness receive a lower quality of care
- High cost of physically ill with mental illness
- **Access problems**

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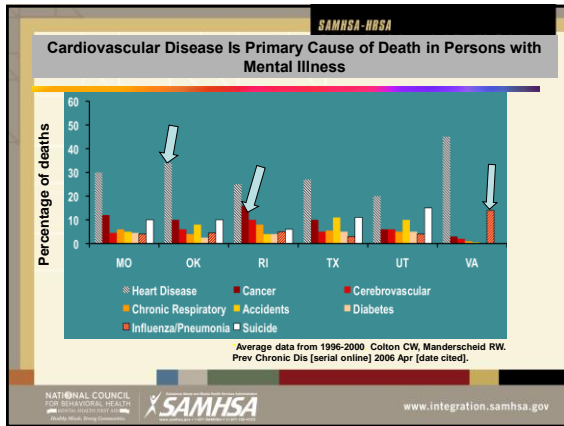
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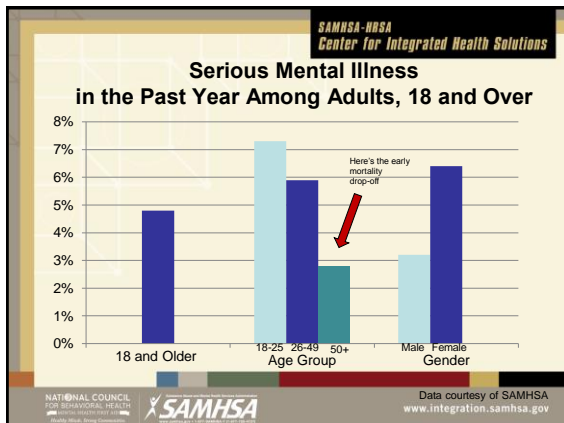
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### Cardiovascular Disease Risk Factors

Modifiable Risk Factors	Estimated Prevalence and Relative Risk (RR)	
	Schizophrenia	Bipolar Disorder
Obesity	45-55%, 1.5-2X RR <sup>1</sup>	26% <sup>5</sup>
Smoking	50-80%, 2-3X RR <sup>2</sup>	55% <sup>6</sup>
Diabetes	10-14%, 2X RR <sup>3</sup>	10% <sup>7</sup>
Hypertension	≥18% <sup>4</sup>	15% <sup>5</sup>
Dyslipidemia	Up to 5X RR <sup>5</sup>	42%
Metabolic Syndrome	43%	37%

1. Davidson S, et al. *Am J Psychiatry*. 2001;158:1996-2002. 2. Allison DB, et al. *J Clin Psychiatry*. 1999; 60:215-220.  
 3. Dixon L, et al. *J Nerv Ment Dis*. 1999;187:496-502. 4. Herman A, et al. *Schizophr Res*. 2006;41:373-381.  
 5. McElroy SL, et al. *J Clin Psychiatry*. 2002;63:207-213. 6. Usisk A, et al. *Psychiatry Clin Neurosci*. 2004;58:434-437.  
 7. Casady F, et al. *Am J Psychiatry*. 1999;156:1407-1420. 8. Alibekov. *Schizophr Bull*. 1998;13(1):81-85. 9. VanCampfort AJP. 2013.

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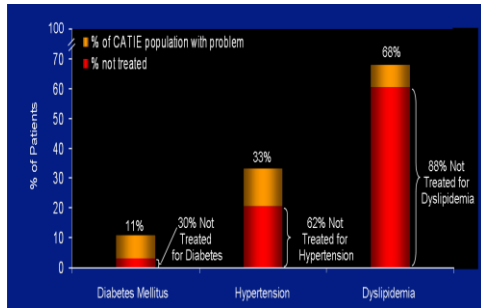
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### Rates of Non-treatment



Nasralla, et al Schizophrenia Research 2006(86)

### History of "SMI" Nomenclature

Severe mental disorders were enumerated and operationalized in 1993 by the National Advisory MH Council at the request of the Senate. They were published in the American Journal of Psychiatry 150: pp 1457 ff. They include schizophrenia, schizoaffective disorders, Bipolar DO, Autism, and severe forms of Depression, Panic disorder, and OCD.

Fuller Torrey, MD

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### Definition: Severe Mental Illness (SMI)

A **mental, behavioral or emotional disorder** (excluding substance & developmental disorders)

**Functional disability** in areas of social and occupational functioning.

**Serious functional impairment**, which substantially interferes with or limits one or more major life activities – GAF <50-60

\*\* 1:20 of population with SMI (vs 1:5 for all mental illnesses)

Spollen JJ Perspectives in Serious Mental Illness, www.medscape.com

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## Global Assessment of Functioning (GAF) Score

61 – 100 No symptoms. Superior functioning in a wide range of activities - Mild symptoms (e.g., depressed mood and mild insomnia) OR some difficulty in social, occupational, or school.

51 - 60 **Moderate symptoms** (e.g., flat affect and circumstantial speech, occasional panic attacks) OR moderate difficulty in social, occupational, or school functioning

41 - 50 **Serious symptoms** (e.g., suicidal ideation, severe obsessional rituals, ) OR any serious impairment in social, occupational, or school functioning

31 - 40 **Some impairment in reality testing or communication** (e.g., speech is at times illogical, or irrelevant) OR major impairment in several areas.

21 - 30 **Behavior is considerably influenced by delusions or hallucinations OR serious impairment**, in communication or judgment (e.g., sometimes incoherent, acts inappropriately, suicidal preoccupation) OR inability to function in almost all areas (e.g., stays in bed , no job)

11 - 20 **Some danger of hurting self or others** (e.g., suicide attempts without clear expectation of death; frequently violent; manic excitement) OR occasionally fails to maintain hygiene , OR gross impairment in communication (e.g., largely incoherent or mute).

1 - 10 **Persistent danger of severely hurting self or others** (e.g., recurrent violence) OR persistent inability to maintain minimal personal hygiene OR serious suicidal act with clear expectation of death.

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## Most Common Diagnosis in SMI Patients

56-70% Schizophrenia

20-34% Bipolar Disorder

10% Major depression, OCD or Borderline Personality disorder

McDevitt J et al. Clinical practice recommendations-Evidenced-based guidelines for integrated care 2002

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## Schizophrenia -Diagnostic Criteria

Two or more of the following:

- **Positive** Symptoms – must have at least 2 and at least one must be hallucinations, delusions or disorganized speech
  - Hallucinations – auditory most common
  - Delusions – paranoid, somatic, grandiose
  - Disorganized Speech
  - Grossly Disorganized or Catatonic Behavior
- **Negative** Symptoms
  - Flat affect – blank look, lack of expression
  - Lack of motivation/drive/desire to pursue goals
  - Lack of additional, unprompted content seen in normal speech patterns – monotone, monosyllabic
- **Social/Occupational Dysfunction**

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### Other Psychiatric Comorbidity in SMI patients

1. Depression – 25%
  1. Suicide
    - 10% of depressed patients with schizophrenia
    - 5% (all causes)
2. Trauma – 29% PTSD
3. Substance Use Disorders
  1. 47% of SMI population use alcohol
  2. 44% Cannabis
  3. 50 – 80 % use tobacco products

Buckley, PF et al. 2009, Padgett, D.K., and E.L. Shrout 1992, Carey KB, CareyMP, Simons JS. 2003, Kaylee H, Taylor M. 2010.

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### Barriers to Providing Primary Health Care to Psychiatric Populations

**Cultural**

- Mental health staff and patients not used to incorporating primary care as part of job
- Psychiatric staff feel time pressure to address screening, vital signs and may feel "out of scope of practice" for specialty

**Financial**

- Very rarely funded.
- Billing medical services challenging
- High no show rate, take extra time
- Psychiatric providers not provided resources to provide care (medical assistants to take vitals before appts, blood pressure cuffs, scales)

**Motivational**

- Lack of perceived need for care
- Lack of motivation as part of negative symptoms of schizophrenia

**Organizational**

- Devoting space, time, and money
- Specialists do not cross boundaries
- Different languages
- Behavioral health EHRs may lack capacity to track physical health indicators
- Not perceived as part of the Mission

**Clinic Location**

- Proximity is crucial to success
- Same building is best
- Space limitations.

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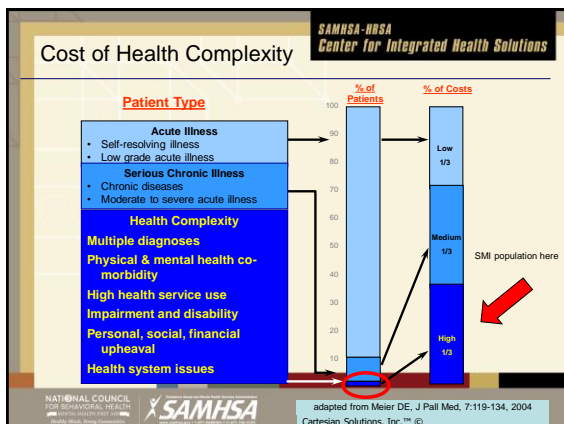
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### Experimenting: Some Developing Models

- PCARE study (Druss et al, 2010)
- SAMHSA/HRSA PBHCI 93 Grantees
- Medicaid State Plan Amendments (SPA)
  - Allow for enhanced Medicaid funding (usually case rate) for Health Home for patients with SMI
  - May be located in a community mental health center so sometimes called "behavioral health home"

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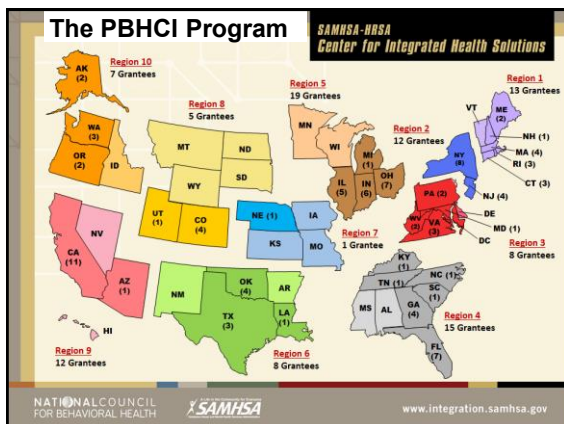
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**“Different models must be tested - the cost and suffering of doing nothing is unacceptable.”**

Vieweg, et al., *American Journal of Medicine*. March 2012

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**Interactive Exercise:  
Reflection and Discussion**

1. What outcomes do we hope to achieve by addressing the health issues in the SMI population?
2. Is this “tomorrow’s model?”

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**Post Test Questions**

1. The premature mortality seen in the SMI population is:
  1. 30 – 40 years
  2. 25 – 30 years
  3. 20 – 25 years
  4. 15 – 20 years
2. What percent of illness contributing to this early mortality is preventable?
  1. 20%
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3. What are the leading illnesses that contribute?
  1. Cardiovascular
  2. Infectious disease
  3. Cancers
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## Post Test Answers

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 Adapted from: Peek, CJ - A family tree of related terms used in behavioral health and primary care integration  
<http://integrationacademy.ahrq.gov/lesson> 2012

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## Module 2 Overview of the Behavioral Health Environment

### Learning Objectives:

- Appreciate the philosophy, funding and organizational structure of public mental health settings
- List the personnel employed in these settings, their job functions and how the teams operate
- Describe the integrated care team roles and responsibilities in these settings

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## Overview of Module 2

- History of public mental health and CMHCs
- Who are the staff?
- Lexicon
- Services provided by team members
- Service planning
- HIPAA
- Recovery Movement

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## Brief History of Community Mental Health

- Intent to move patients out of mental institutions and into the community, based on concept of "moral treatment" of mentally ill—"the insane came to be regarded as normal people who had lost their reason as a result of severe psychological stress....Pinel, 1700s"
- Approval in 1949 of chlorpromazine (Thorazine), and discovery that lithium treats mania
- Community Mental Health Center Act of 1963** – signed by President Kennedy, mostly unfunded
- 1979 – National Alliance of the Mentally Ill (NAMI) organized
- 1980 – National Mental Health Service Systems Act – unfunded, then eliminated entirely under the Reagan administration in 1981– "transitional institutionalization" to nursing homes, jails or prisons, boarding homes, foster care. LA county jail "largest psychiatric hospital in the country"
- Medicare/Medicaid mid 60's – offered some funding for care – partial hospitalization
- Drop in state hospital populations from 5,500,000 to 62,000 by 1996 – managed care
- Late 90's to 2000** – shift from symptom control → rehab → recovery
- 2003 – President Bush, President's New Freedom Commission on Mental Health
- 2008 – Parity Act – equivalent payment for medical and mental health, final rule pending
- 2010 – PPACA – funding for programs such as PBHCl grantees and State Plan Amendments

Feldman, 2012, Textbook of Community Psychiatry

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## “Consumer”

“Consumer” grew out of the individuals’ recovery movement. It was chosen by many advocates because it implied an element of choice in the mental health services used by people living with mental illness. There is some disagreement over this terminology by both patients (consumers) and staff”.

SAMHSA 2010, Newsletter Volume 18 No 3

In certain behavioral health settings, you may find non-medical staff do not use the term “patient”. You may want to use “consumer” with non-medical staff if you are comfortable with this.

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## “Peer” Specialists

Individuals in recovery from mental health problems as service providers – many backgrounds, may not have degree

Use their experiences to help others with mental illness. Offer social support, shared experiential knowledge, broker the needs of patients

Improve activation by motivating patients to participate in their care. Develop WRAP plans (Wellness Recovery Action Plan) with patients

Dual relationships may exist between peer specialists and other treatment providers (such as therapists, the PCP or psychiatric providers) as well as with the patients they serve. Establishing clear boundaries is an important aspect of training peer specialists and other staff.

Vecchio, 2012, Handbook of Community Psychiatry

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## Army of Providers and Array of Services

- Medical – MD, DO, APN, PA
- Psychotherapy – many flavors, see later slide
- Case Management– linkage to community supports
- Crisis Services– manage emergency situations, arrange emergency commitments if needed
- Assertive Community Treatment – ACT- mobile units that reach more severely ill patients
- Peer Services– individuals in recovery from their own mental health conditions helping other patients
- Vocational Support– assist patients in preparing for, finding and being successful in employment
- Substance Abuse Treatment – detox, outpatient groups, medication assistance
- Psychiatric Rehabilitation – develop skills to function in communities
- Clubhouse – Patient and Peer run self support services
- Wellness Education – helps patients manage their symptoms at home

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**Multidisciplinary Team Approach**

Ex: Adult Team Meeting

- Psychiatric Providers
- Case Managers
- Nurses
- Therapists

Discuss patients who are struggling

- Discuss new patient evaluations
- Debrief traumatic events
- Education – med side effects, etc.
- Frequent re-admissions
- Discuss physical health issues with inhouse PCPs**



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**Evidence Based Practices Utilized**

- Medication Guidelines
- Dialectical Behavioral Therapy (DBT)
- Cognitive Behavioral Therapy (CBT)
- Supported Employment
- Assertive Community Treatment (ACT)
- Integrated Dual Diagnosis Treatment (IDDT)
- Family Psychoeducation
- Self Management – Stanford Self-Management, HARP, Living Well, WHAM (Whole Health Action Management)
- IMPACT model proliferation to local primary care clinics

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**Providing Information to Healthcare Providers Across Silos of Care**

- HIPAA permits sharing information, including behavioral health care
- Nationally consent not necessary, stricter local laws may apply
- Exceptions:
  - 42 CFR, Part 2 - Substance abuse treatment
    - Determined by location in which tx occurred and information is being released from
    - Applies to organizations that "hold themselves out" as providing substance abuse treatment, an individual that only does this) – they are bound by 42CFR
    - PCPs can release info they have gathered (ie patient on methadone) independently in their clinic under HIPAA and do not fall under 42 CFR because not a location that provides SA tx
    - Re-release of records from the Methadone Clinic requires consent.
    - Exception? A PCP who works in a methadone clinic!
    - \*\* There has never been a 42 CFR suit



<http://www.samhsa.gov/healthprivacy>

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### EXAMPLE – Mr. Jones

Mr. Jones is a 42 year old male with schizophrenia you are treating in the mental health center where you have been hired as a PCP in a PBHCl grantee site (location where PCP is working is CMHC)

He is getting methadone from a clinic that specifically provides methadone treatment (holds itself out to be Substance Use provider)

Patient tells you he is on methadone and you record this in your chart

You may release the information you have obtained independently and recorded in your chart to his cardiologist under HIPAA and do not need consent under 42 CFR

You request a copy of his record from the Methadone Clinic. They must follow 42 CFR to release for his records to you

You may not re-release his actual record from the Methadone Clinic to the cardiologist without consent under 42 CFR

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### Recovery from Mental Disorders and/or Substance Use Disorders

**Definition:** A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

**Four Dimensions:** Health, Stable Home, Purpose and Community Supports

**Guiding Principles:** recovery emerges from: hope, is person-driven, occurs via many pathways, holistic, supported by peers and allies, culturally based, addresses trauma, involves strengths and is based on respect

SAMHSA 2012  
For more information visit  
[www.samhsa.gov/recovery/](http://www.samhsa.gov/recovery/)

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### Interactive Exercise: Reflections and Discussion

- How do you think you will fit into the this environment?
- Do you see yourself as a ready and willing "team" player?
- What excites you about working in this system?

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## Post test questions

1. The Community Mental Health Center Act is how old this year?
  - a) 10 years
  - b) 30 years
  - c) 40 years
  - d) 50 years
2. Staff found in CMHC environments can include
  - a) Case managers
  - b) Social Workers
  - c) Nurses
  - d) Peers
  - e) All the above
3. With proper access to care , what percent of patients may experience intermediate to full Recovery?
  - a) 10%
  - b) 20%
  - c) 50%
  - d) 70%

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## Module 3 Approach to the Physical Exam and Health Behavior Change

Learning Objectives:

- Understand the prevalence of comorbid behavioral health and medical conditions
- Describe the best approach to the physical exam
- List medical conditions that may mimic psychiatric disorders
- Discuss health behavior change approaches

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## Overview of Module 3

- Comorbidities
- Screening Guidelines and Preventive Care
- Approach to the Exam
- Cultural Considerations
- Advanced Directives
- Health Behavior Change in SMI population

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## Two Worlds

Primary Care	Behavioral Health
Continuity is goal	Termination is goal – “close the chart”
No Stigma	Stigma common
Data shared	Data private
Large panels	Small panels
Flexible scheduling	Fixed scheduling
Fast Paced	Slower pace
Time is independent	Time is dependent – “50 min hour”
Flexible Boundaries	Firm Boundaries
Treatment External (labs, procedures)	Relationship with provider IS treatment
Patient not responsible for illness	Patient responsible for participating in tx

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## Concerns in Approaching the Exam

Providers View	Patients View
WE DON'T UNDERSTAND THEM	THEY DON'T UNDERSTAND ME
THEY ARE MENTALLY ILL	THEY ARE INCOMPETENT
THEY TAKE TOO LONG	THEY AREN'T PATIENT WITH ME
THEY DON'T DO WHAT WE SAY	THEY WANT TO CONTROL ME
THEY SCARE ME	THEY SCARE ME

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## Medical Mimics of Psychiatric Disorders

**Features suggesting a non-psychiatric origin:**

- Late onset of initial presentation
- Known underlying medical condition
- Atypical presentation of a specific psychiatric diagnosis
- Absence of personal and family history of psychiatric illnesses
- Illicit substance use
- Medication use
- Treatment resistance or unusual response to treatment
- Sudden onset of mental symptoms
- Abnormal vital signs
- Waxing and waning mental status

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## Common Medical Complaints

Pain  
abdominal (30.7%),  
head,  
mouth (24%),  
back (14.7%)  
Insomnia  
Cough, Sore Throat, Headache

Cad Saude Publica, 2010 Mar;26(3):591-602

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## Screening/Preventive Services Essential

- ADA/APA guidelines for Second Generation Antipsychotics (SGAs) – Psychiatric providers
- HIV, TB, HCV – many are in “high risk” category
- USPSTF recommendations – age recommended – cancers common
- Substance Use, Smoking, “Medical” marijuana, meth
- Prevention – flu shots, immunizations, etc

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## The Exam Room Set - Up

Anatomic pictures could be viewed as scary  
Consider what you are hanging on the walls – may be frightening, educational material on diet/exercise is good option, patient/consumer art work  
May need to keep the door open for patients with anxiety or paranoia  
Larger exam room to keep from feeling closed in and give the patient and provider space  
Well ventilated – smokers, malodorous patients

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### Approach to the Exam – Reset Expectations



**Longer appointment**  
due to aspects of illness  
such as poverty of speech,  
apathy, disorganization,  
positive symptoms make  
it harder to get accurate  
history. 2-4 appts per hour,  
smaller panel size - half



**Sensitive to Trauma**  
Especially sexual trauma  
In women. Be ready for  
emotional response to exam,  
take time to explain and go  
slow



**Avoid Bombardment**  
Start with one or two  
goals and move through  
the list over the course  
of multiple appointments  
- plenty of pent up need  
has to be managed  
carefully

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### Electronic Health Records

Can be helpful for showing patient x-rays, reviewing notes  
especially if they are worried about what you are telling  
them

Typing can be distracting, including the clicking noise on  
the keypad – gauge how the patient is responding to  
this

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### Positive Symptoms that may Interfere with Examination

- Delusions
  - Paranoid – someone is out to get me
  - Somatic – have cancer, guts are rotting, bug eggs in my scalp
- Disorganization
  - Dress
  - Language
  - Hygiene
- Hallucinations – especially auditory-
  - Could say provider is going to “harm”
  - Could say provider is “good”
  - Could say patient is “stupid” to be here



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### Positive symptoms: example

Patient with Bipolar DO, currently manic, refusing medication except for Valium. C/O vaginal discharge. PCP enters room to do pelvic exam and patient found naked, scrubbing the sink. She is smiling, has rapid speech and states she is not ashamed to be seen in her “birthday suit”.

**\*\*What approach would you take with this patient?**

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### Negative Symptoms – Absence of ....

- Speech – monosyllabic, less overall, monotone
- Motivation – can be low
- Interest – disinterest in certain things
- Expression – flat affect
- Gestures – reduced
- Lack of ability to experience joy or act spontaneously



25% have “deficit syndrome” – severe negative symptoms

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## Negative Symptoms: Example

Difficult to assess patient's abdominal pain. He does not volunteer any information. However, his counselor did send him in for visit given this has apparently been going on for some time. Will get a KUB to start and check for constipation.

Trial of Lansoprazole and close follow up.

He was not able to get a urine sample for us today. Refused to even try.

*PCP note in EMR 2013*

**\*\*What approach might you take with this patient?**

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## Why medical settings may be distressing for people with trauma experiences:

- ☐ Invasive procedures
- ☐ Removal of clothing
- ☐ Physical touch
- ☐ Personal questions that may be embarrassing/distressing
- ☐ Power dynamics of relationship
- ☐ Gender of healthcare provider
- ☐ Vulnerable physical position
- ☐ Loss of and lack of privacy

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## Patients who are Suicidal

Rare events are very difficult to predict

Previous suicide attempt history somewhat helpful in prediction

Take them seriously –

- 15% Bipolar DO - suicide
- 5% Schizophrenia - suicide

Ask about command hallucinations (voices) telling to harm self

Ask how they would do it

Ask if they have means to carry out the plan – pills, firearms, rope

Get help from your team – if a patient is expressing these thoughts there are crisis services available within your system

**\*\*Have a written, well thought out plan for emergencies – who to call**

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## Controlled Substances

- Definitely an issue in patients with SMI – chronic pain common (36%)
- Many patients feel narcotics beneficial for their mental health but actually can make conditions like anxiety and depression worse
- Like any other patient use sparingly and for short duration if possible. Will have to deny request for these medications (frequently) as you do in other medical settings!
- Prevents antidepressants from working (*anti – depressant* vs. *depressant*)
- Contracts helpful – close ALL loopholes (esp. patients with personality disorders) – single provider in clinic for patient
- Methadone and Suboxone useful
- Pregabalin (Lyrica), gabapentin, SNRIs -duloxetine (Cymbalta) and venlafaxine (Effexor) can be helpful for pain

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## Patients who are Agitated: De-Escalation

- Appear calm, centered, self-assured (even if you aren't)
- Limited Eye Contact – not too much, not too little
- Neutral facial expression, eye level, monotone voice
- Minimize body movements, relaxed and alert posture
- Position yourself for safety – separate patient from others
- Don't point or shake finger, do not touch
- Do not get defensive, be respectful while setting limits
- Be honest
- Empathize with feelings but not behavior "I know you feel...but"
- Trust your instincts
- Have a plan for how your office will handle this – call 911, etc

[www.citinternational.org](http://www.citinternational.org)  
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## Pregnancy and SMI

- Gestational complications due to comorbid health behavior problems including smoking, obesity, substance use, sexual practices, teratogenic side effects of medications
- Increased symptoms of psychiatric illness due to insomnia, hormones
- Birth complications – low birth weight, addiction/withdrawal concerns, incidence of return to more severe symptoms (such as psychosis)
- Early infancy – child welfare involvement, adoption, bonding issues
- Need for more intensive oversight, high risk multispecialty clinics key if available

**\*\* Patient involvement in treatment decisions is crucial**

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## Coordinating care with specialists

- Using Care Managers to facilitate referrals and get info back to care team
- Referral form to take with them
- Fax copy of your notes in EMR
- Using Case Managers and Peer Specialists to encourage, get them there – “activation” crucial
- Find specialists that work well with patients with mental illness and treat them with respect

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## Daily Huddles

Allow the practice to plan for changes in the workflow, manage crises before they arise, make adjustments to improve access and staff member's quality of life

Share details of care being provided by individual members so you have a *more comprehensive picture* of the patient

Huddle length – 7-10 min

Huddle leader – can rotate or choose

Bring your laptop – separate EMRs, paper charts

Decide if labs, reports, etc are available – get them in advance

Medication reconciliation in advance of appointment

Check for openings - might be able to work someone in?

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## Mental Health Advanced Directives

- Describes what a patient wants to happen in a future *mental health crisis* when they are not able to decide for themselves or communicate effectively
- Lists the mental health treatments they prefer in an critical situation
- Appoint someone to make mental health decisions for them (proxy decision maker)
- Must be written when competent to do so
- Varies by state [www.NRC-PAD.org](http://www.NRC-PAD.org)

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## Approach to the Exam - Tips

- Calm demeanor -don't challenge delusions – reassurance and understanding, work around the positive symptoms
- Correct misinformation about medical care
- Understand you may get most of your information from staff rather than the patient.
- Purpose of first visit could be introductions, tour, gather information, opportunity for patient to ask questions, make the next appointment
- Maintain appropriate boundaries
- This is team-based care, so use the resources of the team
  - Co-visits with other staff (case managers, peers), huddles to pre-plan – chart review and medication reconciliation before the patient enters the room
- Slower pace
- **Be willing to cut the visit short and try another day!**

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## Example – first visit

H. B. is a 57 yr old AA female with Schizoaffective DO who presents with Case Management staff. She has been to the office before just to stand in the waiting room and come back and "check out" the exam room. Last week, I was able to talk to her briefly between patients and she said that her toe nails were too long. Maybe I could help with that. This week she comes to the exam room with staff and allows a check of her BP and after cutting one toe nail, tells me that hurt and she will think about cutting the rest, despite the fact that her feet look like bird claws. Eventually, we may be able to further exam the patient and even get blood work. This may take several months.

PCP in Pennsylvania

**\*\*How would you approach this patient?**

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## Cultural Considerations

Some cultures tend to have stronger family ties and may want family to be included in treatment planning

Somatic distress often expressed instead of emotional distress in some cultures

Different beliefs about healing should be explored

Drug metabolism can be effected by race

Under diagnosis in people of color is an issue

Culturally diverse staff helpful






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## Health Behavior Change



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## Effects of Interventions to Reduce Risks of CVD – *Small* Changes Can Have Significant Impact

**Blood cholesterol**

- 10% ↓ = 30% ↓ in CVD (200-180)

**High blood pressure (> 140 SBP or 90 DBP)**

- ~ 6 mm Hg ↓ = 16% ↓ in CVD; 42% ↓ in stroke

**Diabetes (HbA1c > 7)**

- 1% point ↓ HbA1c = 21% dec in DM related deaths, 14% decrease in MI, 37% dec in microvascular complications

**Cigarette smoking cessation**

- ~ 50% ↓ in CVD

**Maintenance of ideal body weight (BMI = 18.5-25)**

- 35%-55% ↓ in CVD
- 5 – 10 % decrease can lead to "clinically significant" changes

**Maintenance of active lifestyle (~30-min walk daily)**

- 35%-55% ↓ in CVD

Stratton, et al. BMJ 2000  
Hennekens CH. Circulation 1996;97:1095-1102.  
Rich-Edwards JW, et al. N Engl J Med 1986;302:1758-1766.  
Bazzuk SS, Manson JE. J Appl Physiol 2005;99:1193-1204

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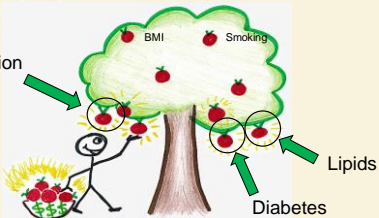
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## Low Hanging Fruit



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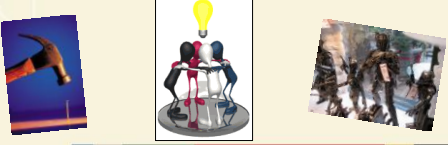
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## “Force Multiplier Effect”

Force multiplication refers to a trait or a combination of traits which make a *given force more effective* than that same force would be without it.



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## How Many Interactions With Patients in Different Settings During a Year?

**Primary Care Settings – 4 – 6?**

**Mental Health Settings:**

- Psychiatrist – 4
- Nurse – 4
- Case Manager – 20
- Therapist/Crisis – 5
- Peer Specialists

**30 – 40 Opportunities a Year?**

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## A Shared Base of Health Literacy: Medical Knowledge for Non- Medical Staff

What are the illnesses and why should I care? What does it have to do with mental illness anyway?

- **Hypertension** – Systolic? Diastolic? Millimeters of Mercury? Stroke?
- **Diabetes** – what is that Hemoglobin A one C, foot exams?
- **Dyslipidemias** – Ok – I’ve heard of “good” and “bad” cholesterol but what’s the ratio business?
- **Asthma** – inhaled corticosteroids? How do you use that thing?
- **Smoking** – Ok – I know this is bad for you but what does NRT stand for?
- **Obesity** – Got it – this is bad and diet and exercise treat but what is BMI?
- **Health Maintenance** – You mean you want me to encourage my female patients to get PAP smears?

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## Staff Training – Get Creative

- Brown bag lunches 
- Show staff how to use BP cuffs
- One pagers – Diabetes, Hypertension
- Education to give to patients 
- E-mail blasts to all staff – latest news
- Articles/websites
- “Med Spots” at staff meeting (15 minutes)
- Case – To – Care Training

*Kopas-Kerr, Am Fam Physician. 2010 Sep 15;82(6):610-614*  
[http://www.integration.samhsa.gov/workforce/Summary\\_of\\_Case\\_Management\\_to\\_Care\\_Management\\_Training.pdf](http://www.integration.samhsa.gov/workforce/Summary_of_Case_Management_to_Care_Management_Training.pdf)



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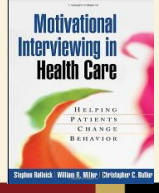
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## Health Behavior Change

Many opportunities in mental health settings!

- A vast body of knowledge and expertise in behavior change
- A few examples of health behavior change models:
  - Health Belief/Health Action Model
  - Relapse Prevention Model
  - Health Action Process Approach
  - Motivational Interviewing



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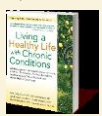
## Self Management


Programs designed to help people gain self-confidence in their ability to control their symptoms and explore how their health problems affect their lives

**Stanford Self-Management Program**  
 6 weeks  
 Topics: dealing with emotions, exercise, nutrition, medications, communication, decision making

**Using Peers:**

- WHAM – Whole Health Action Management  
[www.samhsa.gov/health-wellness/wham](http://www.samhsa.gov/health-wellness/wham)
- HARP – Health and Recovery Peer Program



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## Shared Decision Making

Shared decision-making is an interactive and collaborative process between individuals and their health care providers that is used to make health care decisions pertinent to an individual's personal recovery.

Approach involves both patients and medical provider *discussing options, reaching consensus and deciding on best course of treatment together as partners*. This is consistent with the values of choice, self-determination, and empowerment and provides a means of enhancing consumer involvement in mental health care which has recognized benefits for positive treatment outcomes.

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## Shared Decision Making Exercise

Example: A 67 year old female with schizoaffective DO and severe knee DJD comes in because she cannot stand the pain any longer. She has exhausted medical remedies and you advise referral for surgery. The patient refuses the surgery and decides to live with the pain and disability. Although you advised the patient to have the procedure, the risk of mortality is low and if she refuses you continue to help her with non-surgical remedies and revisit when the patient is ready to discuss

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## Person-Centered Treatment Plan

- Plan provider and patient create so everyone knows what is going on
- Involves collaboration, partnership and shared decision making
- Reduces fragmentation of services
- Serves as a roadmap to guide the recovery process
- Identifies everyone's role in the treatment
- Identifies outcomes (both BH and physical)
- Used to monitor progress and recovery

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## Interactive Exercise: Reflections and Discussion

How might you approach patients differently given the information you have received?

What staff education do you think would be beneficial to maximize the "force multiplier effect"?

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## Module 4 Psychopharmacology for Common Illnesses and Working with Psychiatric Providers

Learning Objectives:

- Understand the most commonly used psychotropic medications and their potential side effects
- Discuss the problems associated with psychotropic prescribing and the role of the PCP-Psychiatric provider liaison in minimizing risk
- Appreciate the need to work with psychiatric provider colleagues on ownership of prescribing and rules of engagement

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## Overview Module 4

- Medication Classes
- Anxiety
- Sleep
- Smoking
- Substance Use
- Pain
- Working with Psychiatric Providers

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## Classes of Psychotropic Medications

Antipsychotics – 1<sup>st</sup> and 2<sup>nd</sup> Generation (SGA)  
 Antidepressants – TCA, SSRI, SNRI, SDRI  
 Mood Stabilizers  
 Anxiolytics



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## Decade of the Brain from the Trenches

Antidepressants	Second Generation Antipsychotics (SGA/"Atypical")
1987 – Prozac (fluoxetine)	1991 – Clozaril (clozapine)
1989 – Celexa (citalopram)	1994 – Risperdal (risperidone)
1989 – Wellbutrin (bupropion)	1994 – Zyprexa (olanzapine)
1992 – Zoloft (sertraline)	1995 – Seroquel (quetiapine)
1992 – Paxil (paroxetine)	2001 – Geodon (zispriazidone)
1993 – Luvox (fluvoxamine)	2002 – Abilify (aripiprazole)
1993 – Effexor (venlafaxine)	x

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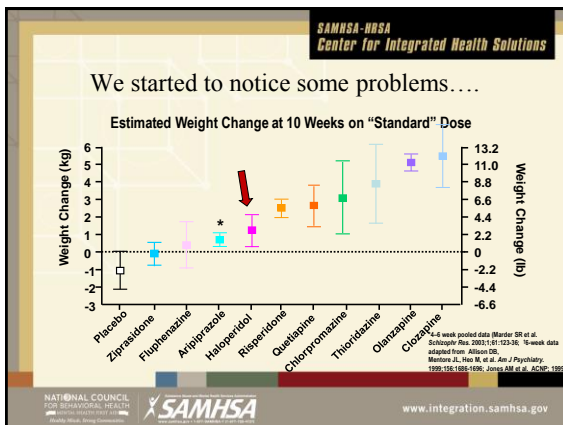
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## CATIE Trial

The NIMH-funded Clinical Antipsychotic Trials of Intervention Effectiveness (CATIE) Study was a nationwide public health-focused clinical trial that compared the effectiveness of older (first available in the 1950s) and newer (available since the 1990s) antipsychotic medications used to treat schizophrenia. \$42.6 million study was conducted over a five-year period at 57 clinical sites across the country.

**Perphenazine:** (FGA)  **Olanzapine, risperidone, ziprasidone, quetiapine** (SGA)

*Perphenazine (the older medication) equally as effective as the other three newer medications (risperidone, quetiapine, and ziprasidone) and was as well tolerated as the newer drugs. The three newer medications performed similarly to one another. Slight clinical advantage with olanzapine. No substantial advantage of newer medications.*

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## So why did we continue to use SGAs with CATIE trial results?

- **\*\*Efficacy**
- **\*\*Less sedation/more sedation**
- **\*\*Patient preference**
- Low incidence of extra pyramidal symptoms
- Low incidence of tardive dyskinesia
- Cannot tolerate alternatives

Hermes, et al. Prescription of Second Generation Antipsychotics: Responding to Treatment Risk in Real World Practice, Psych Services, 2013 64 (3)

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## Why Not Just Switch?

If switch could get weight loss, lower FBS, favorable lipid profile, right?

**Problems that might occur:**

- rebound worsening of psychotic symptoms,
- side effects, such as the addition of side effects of the old and new drugs, or side effects specific to the new drug, or
- differences in efficacy between the drugs and concerns about unequal efficacy
- problems might be specific to the discontinuation of the drug or to the drug to which the patient is switched.

**The strategy (sometimes called "overlap and taper")**

- slow tapering of the initial antipsychotic after the new drug had been titrated to the full dose
- ensures that the patient is covered with an adequate plasma level of the added drug before the former drug is discontinued
- produces fewer problems during the switch than abrupt discontinuation or gradual discontinuation before starting a new drug.

Cochrane Database Syst Rev. 2010 Dec 8;(12):CD006629.  
BMC Medicine 2008, 6:18

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## Approaches to Anxiety

Relaxation Exercises – deep breaths  
Cognitive Behavioral Therapy

**SSRIs, SNRIs (first line med)**  
Fluoxetine, paroxetine, sertraline, citalopram  
Duloxetine, venlafaxine

**Others**  
Benzodiazepines –  
Alprazolam (3hr half life)  
lorazepam (8 hr half life),  
clonazepam (18 hr half life)  
diazepam (60 hr half life)  
Gabapentin – 300 – 3000 mg (wt gain, loquiness)  
Buspirone  
SGAs  
B blockers  
*NOT Bupropion - can worsen anxiety*

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## Rational Approach to Benzodiazepines

- Efficacy, rapid onset make them desirable
- Acute stress, fluctuating anxiety, severe panic are indications
- Limit use to acute episode if possible (4 weeks max) – can become difficult to stop this though
- Use in conjunction with other strategies – SSRI, therapy
- Side effects include sedation, tolerance, cognitive impairment, concern with increased risk of dementia, early mortality
- Base choice by half-life:  
short anxiety attacks, events – alprazolam (3 hours)  
sleep, intermediate coverage – lorazepam (6-8 hour)  
longer term coverage – clonazepam (18 hours)

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## SLEEP

**Sleep hygiene (non pharmacologic approach) first!**  
Naps common due to medication side effects and interfere with normal sleep patterns

**Trazodone 25 – 200 mg**  
**Gabapentin 300 – 900 mg**  
**Mirtazapine 15 mg**  
**SGAs – especially quetiapine**  
**Benzodiazepines**  
**Zolpidem – generic, 5 mg for women**



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## Obstructive Sleep Apnea (OSA)

15% of patients with schizophrenia with OSA  
Common with obesity  
Excessive daytime sleepiness overlaps with other symptoms of mental illness  
Combination of sleep medications, sedating medications, narcotics, benzodiazepines on top of OSA a concern – don't want to make the problem worse

**Tips:**  
 \*\*Find a sleep lab willing to work with your patients  
 \*\*Train case managers in importance of testing so they can help with follow-through

Benson KL, Zarcone VP. Sleep abnormalities in schizophrenia and other psychotic disorders. In: Oldham JM, Riba MB, eds. Review of Psychiatry. American Psychiatric Press; 1994:677-705

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## Chronic Pain

SNRIs – Venlafaxine, duloxetine – some additional benefit with chronic pain due to norepinephrine activity  
Gabapentin – up to 3,000 mg – watch dizziness, weight gain, renal clearance  
Narcotics are CNS depressants so interfere with antidepressant action. Many chronic pain patients are depressed so do not get antidepressant benefit

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## Polypharmacy

- 40% of patients with schizophrenia took 2 antipsychotics
  - Add on quetiapine for sleep common
- Common: 1 or 2 antipsychotics, med for side effects, antidepressant, anxiolytic
- \*\*Reconciliation with other meds important and difficult to accomplish. Use your Care/Case managers, EMR
- Work as a team with your psychiatric providers to avoid duplication
- Find non-pharmacologic interventions when possible



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Ganguly R. J Clin Psych 2004

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### Day in the life of a psychiatric provider

49 yo female, Anxiety, citalopram 40 mg (the easy one – not SMI)  
 53 year old female, Bipolar I, lamotrigine 400 mg, Abilify 15 mg, chlorpromazine 300 mg, fluvoxamine 100 mg  
 33 year old male, Schizoaffective DO, Invega Sustenna, sertraline 100 mg, trazodone 100 mg, trileptal 300 bid  
 28 year old male, Schizoaffective DO, Invega Sustenna 234 mg, Invega 6 mg, Trazodone 100 mg, Depakote 1000 mg  
 41 year old female, Schizophrenia, olanzapine 10 mg, topomax 100 mg bid, trazodone 100 mg  
 53 year old male, Schizophrenia, Invega Sustenna, Bupropion SR 300 mg, trazodone 150 mg, citalopram 40 mg

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### Non Pharmacologic Approaches: Evidence Based Therapies

Cognitive Behavioral Therapy (CBT) for residual psychotic symptoms and anxiety disorders  
Dialectical Behavioral Therapy (DBT) for personality disorders, chronically suicidal patients, teaches Distress Tolerance Skills  
Motivational Interviewing – for health behavior change including smoking, weight loss, alcohol use, exercise  
Behavioral Activation – great for patients that are “stuck”

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### Smoking Cessation – Use your Team

2 mg per day  
Watch for suicidal ideation

21 mg/day start for most  
Watch for smoking while using, may need breakthrough gum/lozenges

Psychosocial Supports (Case Manager, Peers)

300 mg/day- Watch for activation

Konradi et al. The Schizophrenia Patient Outcomes Research Team (PORT). Updated treatment recommendations. SMI Bulletin 36: 94-103, 2010

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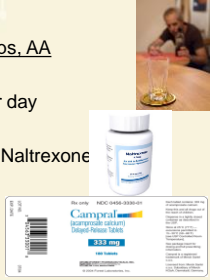
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## Alcohol Treatment

Double Trouble, Peer Run Groups, AA

- Naltrexone - 50 – 100 mg per day (watch hepatic functions)
- Vivitrol – injectable version of Naltrexone
- Campral - 333 mg, 2 tid (renal impairment)
- Antabuse - 250 mg per day



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## Working with Psychiatric Providers

Co-Management	Manage with Primary Care Consult	Comprehensive Management
<ul style="list-style-type: none"> <li>• Each provider has their own caseload</li> <li>• PCP manages all medical problems</li> <li>• Psychiatrist manages all mental health problems</li> <li>• Work together to re-enforce treatment plans</li> </ul>	<ul style="list-style-type: none"> <li>• Psychiatrist works with a care manager</li> <li>• Manages a caseload of patients for BOTH mental health and basic medical health concerns using protocols from PCP</li> <li>• PCP available for consultation and stepped care as needed</li> </ul>	<ul style="list-style-type: none"> <li>• Typically dually trained psychiatrist – Psych/FP, Psych/IM, Child Psych/Peds</li> <li>• Provider manages both medical and mental health problems</li> <li>• Limited number of providers have this expertise</li> </ul>

**All psychiatrists are responsible for "not making people sicker."**

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## Psychiatric Providers' Responsibilities

- **Minimize:** Effects of SGAs and other psychotropic medications
- **Screen:** For Illness (APA/ADA Guidelines, etc.), others
- **Counsel:** Lifestyle Modification – smoking, weight loss
- **Treat:** Some chronic medical conditions with adequate training/consultation if desired

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### Engage Psychiatric Providers

- Shared patients, shared illnesses – they can counsel, switch meds, minimize side effects, treat – work in partnership with PCP
- Patients see them as their “doctor” and may want their approval first before starting medications from PCP
- Complications of psych meds and medical comorbidities require discussion among colleagues

**TIPS**

- \*Staffing complicated patients together is encouraged
- \*Go to medical staff meetings – be part of their team
- \*Educate – help restore their skills in treating chronic medical problems – help them be more well-rounded medical providers

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### Working with Psychiatric Providers

- Some places have no nurses, no MAs and psych feel stressed about trying to do this all themselves with scales and blood pressure cuffs
- Can be insecure about medical skills
- Uncomfortable treating other medical problems “out of my scope of practice”, “not safe”. Liability concerns.
- Check in with each other before changing each others meds, agree on changes
- May see this as intrusive meddling instead of much needed support? These are “their” pts
- ***We’re on the same team so lot of potential for successful partnerships!***



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### Examples – Working with Psychiatric Providers

**Psych A** is community psychiatrist that has been working for the past 12 years with patients in an urban setting. She feels constrained by the 15 minute med check environment and wishes that she has more time to talk with her patient’s and develop a therapeutic alliance more often. She feels that checking vital signs, weighing the patient and talking about lifestyle changes is impossible without more staff and time for patient interaction. Her patients have a number of complex medical problems. She does not have time to call and discuss patients since she does not have a nurse or MA assistant. She has a 16 week back log for new patients.

**\*\* How might a partnership with this psychiatrist improve patient care?**

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## Interactive Exercise: Reflections and Discussion

What do you see as the boundaries of care with your psychiatric colleagues?

What might be a best approach to discussing care concerns, such as a patient with cardiovascular disease on olanzapine, with psychiatric provider?

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## Module 5 Roles for PCPs in the Behavioral Health Environment

Learning Objectives:

- Understand the range of opportunities for PCP inclusion in the health care team
- Appreciate the PCP's contribution to population management strategies
- Discuss the characteristics of a "best fit" PCP for working with SMI patients in public mental health settings

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## Overview Module 5

- Direct Care
- Collaboration
- Population Management
- Education
- Leadership

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### Roles for PCPs in CMHCs



Direct Care	<ul style="list-style-type: none"> <li>Chronic Medical Conditions</li> <li>Preventive Care</li> </ul>
Collaboration	<ul style="list-style-type: none"> <li>Psychiatric Providers</li> <li>Care Managers, Case Managers,</li> </ul>
Population Based Care	<ul style="list-style-type: none"> <li>Establishing Priorities</li> <li>Track Outcomes, Adjust Care</li> </ul>
Education	<ul style="list-style-type: none"> <li>Non Medical and Medical Staff</li> <li>Patients</li> </ul>
Leader	<ul style="list-style-type: none"> <li>Champion Health Care Change</li> <li>Help Shape System of Care</li> </ul>

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### Consultation and Collaboration: *Building Partnerships for Health Improvement*

- Clinical Team meetings with Care Managers, Case Managers, Psychiatric Providers, Peer Specialists and others
  - Identify high risk patients who need immediate attention
  - Review those that are not improving and change treatment
  - Patients new to the system
- Chance to influence delivery of care with administrative staff in CMHC – will need their help with directing non-medical staff
- Assessing the quality of care provided by others – community-based PCPs, specialists, psychiatric providers
- Consult with psychiatric provider team for medical problems

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### Population Management: *Making a Difference For a Larger Population*

"What gets measured gets done"

- Metrics – HEDIS 2013 (NCQA) – pick a few for site
- Benchmarking – local, state, national, by provider, etc
- Registries – to track, allows you to see specifics
- Claims Data – to prioritize high utilizers, other gaps

Use data to establish priorities and then adjust approach


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## Registries

- Systematic collection of a clearly defined set of health and demographic data for patients with specific health characteristics
- Held in a central database for a predefined purpose
- Medical registries can serve different purposes—for instance, as a tool to monitor and improve quality of care including risk stratification, or as a resource for epidemiological research.



J Am Med Inform Assoc. 2002 Nov-Dec; 9(6): 600-611

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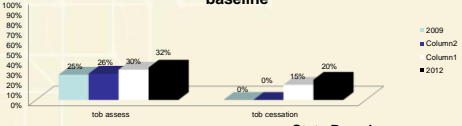
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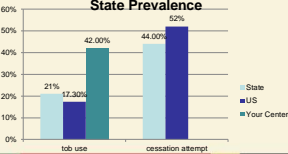
### Your Center's Tobacco screening and assistance baseline



**Center Goals**

- Tobacco use assessment  
100% of patients >18y/o
- Cessation assistance  
50% of Tobacco users
- Improve documentation

**State Prevalence**



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	Goal	All Providers	PCP 1	PCP 2	PCP 3	PSY 1	PSY 2
Smoking Assessment	100%	38%	25%	60%	50%	0%	0%
Cessation Advised	50%	23%	5%	50%	20%	0%	0%

Some History:  
 \*PSY doesn't use the same EMR  
 \*An e-mail was sent out to announce this initiative to providers  
 \*PCP2 is the chair of the improvement committee

**How would you use this data to improve care?**

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## Looking over the shoulder of your colleagues:



Emphasis how this supplements and does not duplicate or interfere with the care provided by others

Not looking for "good" or "bad" providers, just helping with things that were missed

Some will appreciate your help, some will tolerate it, and some may be outright hostile

"You're not in command: you are in negotiation"

Do it because the results can be gratifying, because you want to be an agent of change

Atul Gawande, MD, Big Med  
New Yorker, August 2012

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## Targeted Education

Use outcomes to determine who needs what:

- Administrators
- Psychiatric Providers
- Case Managers
- Care Managers
- Peer Specialists
- Patients



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## A Shared Base of Health Literacy: Medical Knowledge for Non- Medical Staff

What are the illnesses and why should I care? What does it have to do with mental illness anyway?

- **Hypertension** – Systolic? Diastolic? Millimeters of Mercury? Stroke?
- **Diabetes** – what is that Hemoglobin A one C, foot exams?
- **Dyslipidemias** – Ok – I've heard of "good" and "bad" cholesterol but what's the ratio business?
- **Asthma** – inhaled corticosteroids? How do you use that inhaler?
- **Smoking** – Ok – I know this is bad for you but what does NRT stand for?
- **Obesity** – Got it – this is bad and diet and exercise treat but what is BMI?
- **Health Maintenance** – You mean you want me to encourage my female patients to get PAP smears?

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## Educating Psychiatric Providers

<b>1<sup>st</sup> LINE: Thiazide Diuretics</b> Unless have CHF, DM, Chronic Kidney Dz	HCTZ 12.5 mg, 25 mg, 50 mg (max) Chlorthalidone 25 mg (max)	QD dosing. Check electrolytes 4-6 weeks, then q 3 mos, then annually. Add second agent if partial response S 4 list - both
<b>2<sup>nd</sup> LINE: ACE Inhibitors</b> 1 <sup>st</sup> line for above dx	Lisinopril 5mg, 10 mg Enalapril 2.5mg, 5 mg, 10 mg, 20 mg	Start at 5-10 mg/day and titrate up to as much as 40 mg per day. Check electrolytes 8-10 weeks. Stop if CR > 2.5. Once a day, dry cough, elev CR, angioedema, facial swelling, do not use in pregnancy
<b>3<sup>rd</sup> LINE: Calcium Channel Blockers</b>	Amlodipine 2.5 mg, 5 mg, 10 mg (max) Nifedipine LA 30 mg, 60 mg, (max 90 mg)	Very potent, if adding as 3 <sup>rd</sup> agent call PCP first! can cause peripheral edema S 4 list
<b>4<sup>th</sup> LINE: Beta Blockers</b>	Metoprolol succinate (XL) 25, 50, 100, 200 (200 mg max)	Once a day. Do not give if Pulse < 55, 25 - 100 mg/day usual, can go to max 200 mg
<b>** Remember BP 139/89 is fine for all patients</b>	Adjust meds q 2 weeks, follow q 3-6 mos once stable	If K <sup>+</sup> falls below nl and BP responding, add 10 meq K <sup>+</sup> up to total dose 20 mg

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
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## Educate Patients

**Formula for Good Health**

Place a ✓ for what you already do and an X for what you need to start doing.

<input type="checkbox"/> 0	<b>Cigarettes</b>	
<input type="checkbox"/> 5	Servings of fruits and vegetables per day	
<input type="checkbox"/> 10	Minutes of exercise, recreation, or meditation per day	
<input type="checkbox"/> 30	Body Mass Index < 30 kg/m <sup>2</sup>	
<input type="checkbox"/> 150	Minutes of exercise per week (e.g., brisk walking or equivalent)	

**What Can A Healthy Lifestyle Do For You?**

(Research studies from the world's leading journals and peer-reviewed journals have shown that...)

- Type 2 Diabetes is 50% less likely to develop
- Heart disease is 50% less likely to develop
- Hypertension is 50% less likely to develop
- Stroke is 50% less likely to develop
- Atherosclerosis is 50% less likely to develop

This is the #1 way to stay healthy and prevent chronic disease!

Am Fam Physician. 2010 Sep 15;82(6):610-614  
<http://www.aafp.org/afp/2010/0915/p610.html>

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## Leadership

- You can be one of the champions for health care change by bringing your knowledge of general medicine into the behavioral health environment
- PR, PR, PR – can be difficult sometimes to get the team to follow



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**If you build it, they will not necessarily come...**

Putting co-located primary care provider in place →  
Very little business!



**Why not?**

- Separate FQHC registration a significant barrier.
- It turns out staff are needed to shepherd the transition, even in the same office suite.
- All CMHC staff didn't have message repeated and repeated and repeated...
- What seems like a lot of CMHC patients is a trickle for the FQHC!

John Kern, MD

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**PCPs who are a "good fit" for this work**

- Flexible
- Adapts well to behavioral health environment
- Likes working with patients with mental illnesses
- Enjoys being part of a team
- Want to make a difference in a health disparity group
- Prefer to use data to drive care including utilizing a "treat-to-target" approach to meet goals

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**PCP Best Suited for This Work**

"My observations are that the key variable is a seasoned/experienced, confident provider who may not fully understand but isn't frightened or put off by issues of mental illness - we've had multiple folks fitting this description who have functioned very well in behavioral health-based primary care clinics.

PBHCI grantee, Colorado

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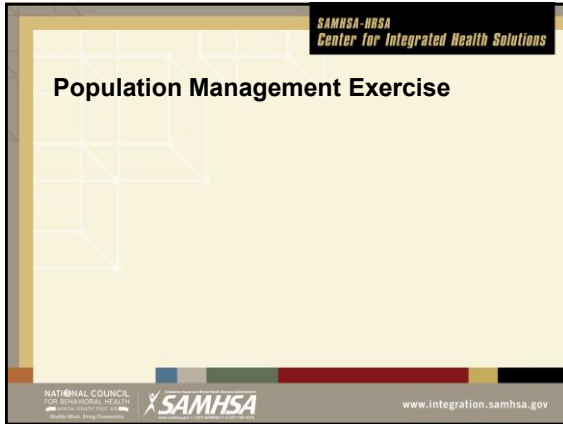
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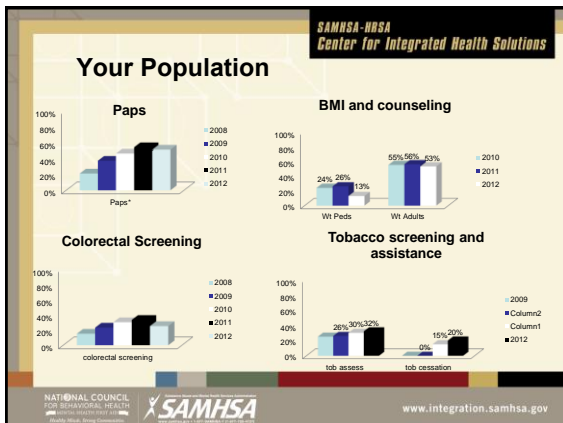
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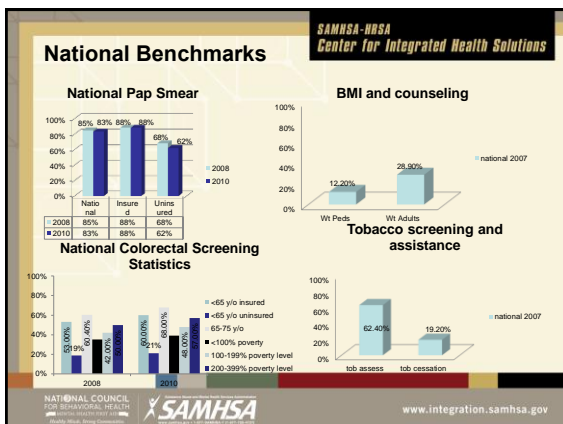
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## What is your Performance Improvement Plan?

Select the Measurement you will target 1<sup>st</sup>  
 What is your goal?  
 How often will you report progress to your team?  
 3 areas of your NCQA certified PCMH you will leverage to meet your goal?

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## Interactive Exercise: Reflections and Discussion

Is this for me? SMI patients?  
 Population based care: What about the 25?, Make a difference for a larger population  
 Humility, discipline and teamwork essential  
 Exciting work. "Collaborative care can change you in ways you never imagined."  
 Psychiatric providers need your help taking care of these patients  
 This can make practicing primary care more rewarding, extend competence into new areas

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## Your Feedback

Do you find this helpful for introducing PCPs to the work of CMHC's?

What else would you like to see included?

Other comments?

We invite you to stay if you'd like to discuss further!

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